HOUSE BILL 481

By Powers

AN ACT to amend Tennessee Code Annotated, Title 56; Title 63 and Title 68, relative to certain practices of health insurance issuers and similar entities.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-3103(a)(3), is amended by deleting the subdivision in its entirety and by substituting instead the following:

(3)

(A) Any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record may not, in and of itself, constitute fraud; however, the claims may be subject to recoupment, repayment, or offset, except as otherwise provided in subdivision (a)(3)(B). Notwithstanding any other law to the contrary, no such claim shall be subject to criminal penalties without proof of intent to commit fraud.

(B) No audit finding, denial of reimbursement, or demand for recoupment, repayment, or offset against future reimbursement shall be made for any claim for dispensing of an original or refill prescription, or changes to a prescription, on the basis of any clerical or record-keeping error, unless:

(i) The entity conducting the audit can provide proof of intent to commit fraud;

(ii) The error results in actual financial harm to the pharmacy benefits manager, covered entity, an insurance plan managed by the pharmacy benefits manager or covered entity, or a patient; or

(iii) The pharmacy or pharmacist fails to correct the errors when the entity conducting the audit requests the correction pursuant to subdivision (a)(3)(C).

(C) The entity conducting the audit may request the pharmacy or pharmacist to adjust an original claim or submit an amended claim to correct any clerical or record-keeping error submitted by the pharmacy or pharmacist. The entity conducting the audit shall provide the pharmacy or pharmacist an opportunity to correct the claim, which may be corrected through an online submission. If the pharmacy or pharmacist does not correct the claim within fourteen (14) days of receipt of the request, then the entity conducting the audit may make an audit finding, deny reimbursement, or demand recoupment, repayment or offset of the funds paid on the requested claim and shall not be in violation of subdivision (a)(3)(B).

SECTION 2. Tennessee Code Annotated, Title 56, Chapter 7, Part 1, is amended by adding the following as a new section:

56-7-136.

(a) As used in this section:

(1) "Covered entity" means a health insurance issuer, dental insurance issuer, managed health insurance issuer as defined in § 56-32-128, nonprofit hospital, medication service organization, insurer, health coverage plan, dental service plan, health maintenance organization licensed to practice pursuant to this title, a health or dental program administered by the state or its political subdivisions, including the TennCare programs administered pursuant to the waivers approved by the United States department of health and human services, nonprofit insurance companies, prepaid plans, self-insured entities, and all other corporations, entities, or persons, or an employer, labor union, or other

group of persons organized in the state that provides health or dental coverage to covered individuals who are employed or reside in the state. "Covered entity" does not include a health or dental plan that provides coverage only for accidental injury, specified disease, hospital indemnity, medicare supplement as defined in § 1882(g)(1) of the Social Security Act, codified in 42 U.S.C. § 1395ss(g)(1), disability income, other long-term care, or other limited benefit health or dental insurance;

(2) "Health care provider" means any physician or dentist licensed pursuant to title 63 and authorized by law to dispense prescriptions;

(3) "Prescription benefits" and "prescriptions" means any drugs, medications, medical devices, or chemicals dispensed pursuant to a prescription. "Prescription benefits" includes the provision of counseling of, or fitting of medical devices, including prosthetics and durable medical equipment; and

(4) "Prescription benefits manager" means a person, business or other entity and any wholly or partially owned subsidiary of the entity, that administers the prescription benefits plan or other portion of insurance coverage provided by a covered entity whereby a patient receives prescription benefits. "Prescription benefits manager" includes, but is not limited to, a health insurance issuer, dental insurance issuer, managed health insurance issuer as defined in § 56-32-228(a), nonprofit hospital, medication service organization, insurer, health coverage plan, dental service plan, health maintenance organization licensed to practice pursuant to this title, a health or dental program administered by the state or its political subdivisions, including the TennCare programs

administered pursuant to the waivers approved by the United States department of health and human services, nonprofit insurance companies, prepaid plans, self-insured entities, and all other corporations, entities or persons acting for a prescription benefits manager in a contractual or employment relationship in the performance of prescription benefits management for a covered entity.

(b) When an audit of prescription benefits records of a health care provider is conducted by a covered entity, prescription benefits manager, the state or its political subdivisions, or any other entity representing the same, any clerical or record-keeping error, such as a typographical error, scrivener's error, or computer error, regarding a required document or record may not, in and of itself, constitute fraud; however, the claim submitted by the health care provider may be subject to recoupment, repayment, or offset, except as otherwise provided in subsection (c). Notwithstanding any other law to the contrary, no such claim shall be subject to criminal penalties without proof of intent to commit fraud.

(c) No audit finding, denial of reimbursement, or demand for recoupment, repayment, or offset against future reimbursement shall be made for any claim for dispensing of an original or refill prescription, or changes to a prescription, on the basis of any clerical or record-keeping error, unless:

(i) The entity conducting the audit can provide proof of intent to commit fraud;

(ii) The error results in actual financial harm to the covered entity, prescription benefits manager, an insurance plan managed by the covered entity or prescription benefits manager, or a patient; or

(iii) The health care provider fails to correct the errors where the correction is requested pursuant to subsection (d).

(d) The entity conducting the audit may request the health care provider to adjust the original claim or submit an amended claim to correct any clerical or record-keeping error submitted by the health care provider. The entity conducting the audit shall provide the health care provider an opportunity to correct the claim, which may be corrected through an online submission. If the health care provider does not correct the claim within fourteen (14) days of receipt of the request, then the entity conducting the audit may make an audit finding, deny reimbursement, or demand recoupment, repayment or offset of the funds paid on the requested claim and shall not be in violation of subsection (c).

(e) No contract entered into or renewed on or after the effective date of this act shall contain provisions in violation of this act.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following as a new section:

56-7-2369.

(a) For the purpose of this section, "durable medical equipment" means such term as it is defined in § 67-6-102.

(b) No health insurance issuer and no managed health insurance issuer may:

(1) Deny any provider of durable medical equipment the right to participate as a participating provider in any policy, contract or plan on the same terms and conditions as are offered to any other provider of durable medical equipment services under the policy, contract, or plan; provided, that nothing in this subdivision (b)(1) shall prohibit a managed health

insurance issuer or health insurance issuer from establishing rates or fees that may be higher in non-urban areas, or in specific instances where a managed health insurance issuer or health insurance issuer determines it necessary to contract with a particular provider in order to meet network adequacy standards or patient care needs; and

(2) Prevent any person who is a party to or beneficiary of any policy, contract or plan from selecting a durable medical equipment provider of the person's choice to furnish the durable medical equipment services offered under any contract, policy or plan; provided, that the durable medical equipment provider is a participating provider under the same terms and conditions of the contract, policy, or plan as those offered any other provider of durable medical equipment services.

SECTION 4. This act shall take effect July 1, 2013, the public welfare requiring it, and shall apply to contracts entered into or renewed on or after July 1, 2013.